

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH
 County Talbot
 City or town Easton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Memorial Hospital
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Caroline
 City or town Henderson
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

David William Allen

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife _____
 7. Birth date of deceased (mo., day, yr.) Sept. 1945
 6. (c) If alive, give age _____ years
 8. AGE: Years _____ Months 7 Days _____ If less than one day 12 hrs. 50 min.

9. Birthplace Delaware
 (Town, county, and state)

10. Usual occupation _____

11. Industry or business

12. Name Clarence Allen
 13. Birthplace Ind.

14. Maiden name Miss Louis Allen
 15. Birthplace Maryland - Goldsboro

16. Informant Memorial Hospital
 Address Easton Ind.

17. Buried Date thereof 4/22/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Henderson
 Location Henderson Ind.

18. Funeral director Clarence Allen
 Address Goldsboro Ind.

19. 4/29 19 46 M. H. Newer
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 19 46 at 1:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-20-1946 to 4-21-1946
 and that I last saw him alive on 4-20-1946

Immediate cause of death Heart - enteritis - cause not determined

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE B. C. M. D.
 M. D. or other _____

Address Easton Ind. Date signed 4-21-46

RECEIVED

APR 29 1946

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County Talbot CountyCity or town Easton Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution?

10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County TalbotCity or town St. Michaels, Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

George Barnes

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

widowed

6.(b) Name of husband or wife _____

6.(c) If alive, give age _____ years

7. Birth date of
deceased (mo., day, yr.)May 2, 1858

8. AGE:

Years

Months

Days

If less than one day

87

_____ hrs. _____ min.

9. Birthplace

St. Michaels Md.
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

Optician

FATHER

12. Name

James J. Barnes

13. Birthplace

Balto. Md.

MOTHER

14. Maiden name

Louisa Plummer

15. Birthplace

St. Michaels Md.

16. Informant

Daniel R. Barnes

Address

St. Michaels Md.

17.

Burial
(Burial, cremation, or removal. Which?)

Date thereof

April 18, 1946

(month) (day) (year)

Cemetery or crematory

Clerit

Location

St. Michaels. Md.

18. Funeral director

Newman & Harrison

Address

St. Michaels. Md.

19.

4/17

19

46N.H. Norris

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-16-46 19 46 at 1 30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 7 19 46 to April 16 19 46and that I last saw him alive on April 13 19 46Immediate cause of death Myocarditis

DURATION

Due to

Generalized arteriosclerotic

Due to

cardiovascular disease

Due to

Arteriosclerosis

Other conditions

Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE

M. V. Palmer

M. D. or other

Address Easton, Md.Date signed 4/17/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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APR 20 1946
BUREAU V.E.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 928

CERTIFICATE OF DEATH

C4086

★ Reg. Dist. No. 291

1. PLACE OF DEATH:

County Patht
 City or town Royal Oak
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Patht Co
 Hospital, institution, or street address where death occurred: no
 How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MD County Patht
 City or town Royal Oak
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. no
 (If rural, give LOCATION) no
 2.(a) If veteran, name war no

3. (a) FULL NAME

Hattie M Bentley

3. (b) Social Security Number

no

4. Sex female 5. Color or race A.A. 6. (a) Single, married, widowed, or divorced married
 (b) Name of husband or wife Frank Bentley
above 6. (c) If alive, give age about 1897 years

7. Birth date of deceased (mo., day, yr.) about 1897
 8. AGE: Years about 48 Months Patht Co Days Patht Co If less than one day hrs. min.

9. Birthplace Patht Co
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Same as above

12. Name Henry Sullivan

13. Birthplace Wiles River

14. Maiden name Sarah Campbell

15. Birthplace Patht Co

18. Informant Frank Bentley

Address Royal Oak Md

17. Burial Date thereof Apr 4-1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St Paul

Location Royal Oak Md

18. Funeral director James Stewart

Address Salisbury Md

19. April 2 19 46 John W. Winters
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 19 46 at 11:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 15 1945 to April 1 1946 and that I last saw him alive on April 1, 1946

Immediate cause of death Arterial disease

Due to Chor. Rheumatoid Ar

Due to Arterio

Other conditions Hypertension

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. None

Autopsy results None
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide None Date of None

Where did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) None

Means of injury None Injured at work? None

23. SIGNATURE J. Stewart M. D. or other None
John W. Winters Date signed April 2 1946

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MAY 2 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-2

CERTIFICATE OF DEATH

Reg. Dist. No. 04087294

1. PLACE OF DEATH:

County Talbot
 City or town McDaniel
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 65 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md County Talbot
 City or town McDaniel
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Susan A. Berry

3. (b) Social Security Number

none

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced widow

6. (b) Name of husband or wife W. Fredrick Berry

7. Birth date of deceased (mo., day, yr.) July 23 1866 6. (c) If alive, give age _____ years

8. AGE: Years 79 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Essex Virginia
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Charles Baker

13. Birthplace Maine

14. Maiden name Clara A. G. Smith

15. Birthplace Talbot Co. Md.

16. Informant Mr. Lawrence Stewart

Address McDaniel, Md

17. Burial Date thereof April 20, 1946

(Burial, cremation, or removal) Which? _____ (month) (day) (year)

Cemetery or crematory Spring Hill Cemetery

Location Easton, Ind.

18. Funeral director Newnam & Harrison

Address St. Michaels, Ind

19. 4/20/ 19 46 Anna C Thomas

(Date rec'd by registrar) _____ Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 19 46 at 1:40 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 45 to April 17 19 46
 and that I last saw him alive on April 17 19 46

Immediate cause of death Cerebral hemorrhage DURATION 2 yd.

Due to Hypertension; arteriosclerosis

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Gray M. Reese M. D. or other _____

Address Tellico, Md Date signed April 17 1946

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APR 24 1946
BUREAU V. &

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-6

CERTIFICATE OF DEATH

Reg. Diat. No. 290

1. PLACE OF DEATH:

County Subs.City or town Easton
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 17 yrs.

Hospital, institution, or street address where death occurred:

Shenwood Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Subs.City or town Easton
(If outside city or town limits, write RURAL and give nearest town)Street No. Shenwood Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

J. Fletcher Cooper

3. (b) Social Security Number

4. Sex

M.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Mary Cooper

7. Birth date of deceased (mo., day, yr.)

July 4, 18646. (c) If alive, give age 52 years

8. AGE:

Years

Months

Days

If less than one day

8496

hrs.

min.

9. Birthplace

Subs. Maryland
(Town, county, and state)

10. Usual occupation

Merchant

11. Industry or business

MOTHER FATHER

12. Name

James Cooper

13. Birthplace

Md.

14. Maiden name

15. Birthplace

16. Informant

Address

Mrs. Mary CooperEaston, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

April 17, 1946
(month) (day) (year)

Cemetery or crematory

Spring Hill

Location

Easton, Md.

18. Funeral director

Address

Robert A. ...Easton, Md.

19.

(Date rec'd by registrar)

19. 46N. H. Neerius
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10, 1946 at 3:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1944 to April 10, 1946and that I last saw him alive on April 1, 1946

Immediate cause of death

Cerebral Thrombosis

DURATION

8 hours

Due to

Atherosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. V. Palmer

M. D. or other

Address

Easton, MarylandDate signed 4/12/46

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APR 15 1946
BUREAU V.B.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County Talbot
 City or town Pastor
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 da.
 Hospital, institution, or street address where death occurred:
Memorial Hospital
 How long in hospital or institution? 3 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Queen Anne's
 City or town Ruthsburg, Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Mr. Eliza Dean

7. Birth date of deceased (mo., day, yr.)

April 7, 1873
 6. (c) If alive, give age _____ years
 8. AGE: Years 73 Months _____ Days 17 If less than one day _____ hrs. _____ min.

9. Birthplace

Maryland
(Town, county and state)

10. Usual occupation

housewife

11. Industry or business

William H. Sparks

13. Birthplace

Maryland14. Maiden name Harriet Elizabeth Walls

15. Birthplace

Maryland16. Informant Leonard Sparks (Brother)Address Ruthsburg, Md17. Buried Date thereof 5/28/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Denton

Location

Denton

18. Funeral director

J. Virgil Moore & Son

Address

Denton, Md.

19.

(Date rec'd by registrar)

4/26 46N. H. Meier
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 1946, at 7:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
April 23 1946 to April 25 1946
 and that I last saw him alive on April 24 1946

Immediate cause of death

Cardiac renal disease

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

23. SIGNATURE

J. H. Cox M. D. or otherAddress Easton Md Date signed 4-26-46

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MAY 14 1946
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

CERTIFICATE OF DEATH

★ 04690

Reg. Dist. No. 290

1. PLACE OF DEATH:

County 2. Balt.
 City or town Boston, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 yr.
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Subst.
 City or town Boston
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

James Dixon
 4. Sex M. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Married

3. (b) Social Security Number

217019399

6. (b) Name of husband or wife

Elizabeth P. Wright 6. (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.)

May 4, 1872
 8. AGE: Years 73 Months 11 Days 14 If less than one day _____ hrs. _____ min.

9. Birthplace

Subst. Md.
 (Town, county, and state)

10. Usual occupation

Banker & Farmer

11. Industry or business

Robert P. Dixon

12. Name

Md.

13. Birthplace

J. Amanda Dixon

14. Maiden name

Md.

15. Birthplace

Mrs. James Dixon

16. Informant

Boston, Md.

Address

Burial Date thereof April 19, 1946
 (Burial, cremation, or removal? Which?) (month) (day) (year)

Cemetery or crematory

Spring Hill

Location

Boston, Md.

18. Funeral director

William L. Smith

Address

Boston, Md.

19. 4/18

(Date rec'd by registrar)

19 46

N. H. Neerius
 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 19 46 at 12:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10th 19 45 to April 17th 19 46

and that I last saw him alive on April 17th 19 46

Immediate cause of death Adeno Carcinoma

Deciduous Cervix and

Sigmoid

DURATION 1 yr.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE William S. Symons

Easton Md. M. D. or other _____

Address _____ Date signed 4/20/46

RECEIVED
APR 29 1946
BUREAU V. K.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *92a*

CERTIFICATE OF DEATH

04091

Reg. Dist. No. *290*

1. PLACE OF DEATH: *Talbot.*
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....*Md*..... County.....*Talbot.*
 City or town.....*Easton.*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME
Lavinia L. Elliott

3. (b) Social Security Number
212-12-3463

4. Sex.....*Female*..... 5. Color or race.....*Colored*..... 6. (a) Single, married, widowed, or divorced.....*Married*.....

6. (b) Name of husband or wife.....*Robert Elliott*.....

6. (c) If alive, give age.....*41*..... years

7. Birth date of deceased (mo., day, yr.).....*Dec. 2 - 1904*.....

8. AGE: Years.....*41*..... Months.....*4*..... Days.....*10*..... If less than one day..... hrs. min.

9. Birthplace.....*Irytown, Easton, Md. (Rural)*.....
 (Town, county, and state)

10. Usual occupation.....*Housewife*.....

11. Industry or business.....

12. Name.....*George Trippe*.....

13. Birthplace.....*Irytown, Rural Easton, Md.*.....

14. Maiden name.....*Unknown*.....

15. Birthplace.....

16. Informant.....*Robert Elliott*.....

Address.....*Easton, Md.*.....

17. *Burial*..... Date thereof.....*Apr. 15-46*.....
 (Burial, cremation, or removal? Which?) (month) (day) (year)

Cemetery or crematory.....*Chapel Cemetery*.....

Location.....*Chapel Easton, Rural Md.*.....

18. Funeral director.....*John D. Williams*.....

Address.....*Easton, Md.*.....

19. *4/13*..... 19 *46*.....
 (Date rec'd by registrar)

Registrar.....*N. H. Merriam*.....

MEDICAL CERTIFICATION

20. DATE OF DEATH.....*Apr. 12*..... 19 *46*, at *11 a.* M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *April 12th* 19*46* to *Apr. 12th* 19*46*

and that I last saw her alive on *April 12th* 19*46*

Immediate cause of death.....*Left ventricular failure*.....

aortic regurgitation.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

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BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County TalbotCity or town Easton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Easton Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County TalbotCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

ROBERT TYLER HARRISON

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

8. (b) Name of husband or wife

Wattie Jones Harrison

7. Birth date of

deceased (mo., day, yr.)

Sept. 29, 1877

6. (c) If alive, give age

61 years

8. AGE:

Years

Months

Days

If less than one day

6862

hrs. min.

9. Birthplace

Talbot Co. Md.
(Town, county, and state)

10. Usual occupation

Farmer and

11. Industry or business

Stock Dealer

12. Name

William J. Harrison

13. Birthplace

Md.

14. Maiden name

Annie Williams

15. Birthplace

Md.

16. Informant

Mrs. Claude Sweet (Sister)

Address

McDaniel, Md.

17.

(Burial, cremation, or removal, which?)

Date thereof

April 4, 1946
(month) (day) (year)

Cemetery or crematory

Spring Hill

Location

Easton, Md.

18. Funeral director

P. Blair Clark, Inc.

Address

Easton, Md.

19.

4/2
(Date rec'd by registrar)

19

46N. H. Neerues

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1, 19 46, at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 15, 19 46, to April 1, 19 46and that I last saw him alive on April 1, 19 46

Immediate cause of death

Congestive Heart Failure

DURATION

Due to

Mitral Stenosis40 yrs.

Due to

Rheumatic Cardiac Disease40 yrs.

Other conditions

Uremia

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. V. Palmer M.D.

M. D. or other

Address Easton, Maryland Date signed April 5, 1946

EP 140

RECEIVED
APR 11 1946
BUREAU U.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

CERTIFICATE OF DEATH

Dr Lewis
04093

Reg. Dist. No. 290

1. PLACE OF DEATH: Talbot
County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State.....Md.....County.....Talbot
City or town.....Easton
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2(a) If veteran, name war.....

3. (a) FULL NAME
Carrie Jackson

3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married
8. (b) Name of husband or wife Benj Jackson
7. Birth date of deceased (mo., day, yr.) Mar. 17, 1896 8. (c) If alive, give age 50 years
8. AGE: Years 50 Months - Days 22 If less than one day.....hrs.....min.

9. Birthplace Bellverne, Md
(Town, county, and state)
10. Usual occupation Oyster Shucker
11. Industry or business.....
12. Name Jacob Goldborough
13. Birthplace Bellverne, Md
14. Maiden name Harriet Adams
15. Birthplace Bellverne, Md

16. Informant Aubrey Goldborough
Address Bellverne, Md
17. Burial Date thereof Apr. 12, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory St. Luke Cemetery
Location Bellverne, Md
18. Funeral director John Williams
Address Easton, Md
19. 4/10 1946 N. S. Neer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 8th 1946 at 8:30 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1, 1946 to April 8, 1946
and that I last saw her alive on April 8, 1946

Immediate cause of death Lobar Pneumonia; duration 8 to 10 days
DURATION 8 days

Due to ✓ Acquired resistance and apparatus
Due to ✓ ✓
Other conditions ✓
(Include pregnancy within 3 months of death)

Major findings of operations ✓ Date of op. c
Autopsy results ✓
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ✓ Date of.....
Where did injury occur?.....
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ✓ Injured at work?

23. SIGNATURE St. Michaels, Md M. D. or other 4.9.46
Address..... Date signed.....

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APR 15 1946

BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 146

CERTIFICATE OF DEATH

Reg. Dist. No. 04094 290

1. PLACE OF DEATH:

County EasternCity or town Boston
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Boston Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County EasternCity or town Boston
(If outside city or town limits, write RURAL and give nearest town)Street No. P.O. # 4 Box 70
(If rural, give LOCATION)2. (a) If veteran, name war ✓

3. (a) FULL NAME

ELLA VIRGINIA JOHNS

3. (b) Social Security Number

215-16-34244. Sex Female5. Color or race Caucas6. (a) Single, married, widowed, or divorced Single6. (b) Name of husband or wife —6. (c) If alive, give age — years7. Birth date of deceased (mo., day, yr.) January 12, 19208. AGE: Years 26 Months 2 Days 25 If less than one day — hrs. — min.9. Birthplace Boston, Md.
(Town, county, and state)10. Usual occupation Domestic11. Industry or business At home12. Name Thomas Edward Johns13. Birthplace Maryland14. Maiden name Mary Ella Brooks15. Birthplace Maryland16. Informant Mary Ella Brooks JohnsAddress Boston, Md. P.O. # 4 Box 7017. Cremial Date thereof April 9, 1946
(Burial, cremation, or removal. Which?) (Month) (day) (year)Cemetery or crematory Williamstown CemeteryLocation Boston, Md. (Rural)18. Funeral director John BlackAddress Boston, Md.19. 4/9 19 46 N.H. Neeris
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7, 19 46, at 2:45 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-22 19 46, to 4-7-46 19 46and that I last saw her — alive on 4-7-46 19 46Immediate cause of death Retained placentaDue to Sickle Cell AnemiaDue to —Other conditions Pregnancy at term

(Include pregnancy within 3 months of death)

Major findings of operations —Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —Where did injury occur? — (City or town) — (County) — (State)Injured at home, farm, industry, public place (where?) —Means of injury — Injured at work? —23. SIGNATURE J. Tyler Baker M.D.Address Boston, Md. Date signed 4/9/46

RECEIVED
APR 15 1946
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of birth MARYLAND STATE DEPARTMENT OF HEALTH
date of deceased is shown on

2411 N. Charles St., Baltimore *946*

FILM No. I O 4 MAY 20 1946

CERTIFICATE OF DEATH

04095 290
Reg. Dist. No.

1. PLACE OF DEATH

County..... *Talbot*
City or town..... *Easton, Md*
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... *2 1/2 yrs.*
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... *Md.* County..... *Talbot*
City or town..... *Easton*
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

Thos. Edward Johns

3. (b) Social Security Number

None

4. Sex..... *Male* 5. Color or race..... *Colored* 6. (a) Single, married, widowed, or divorced..... *Widowed*

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)..... *Feb. 2, 1852* 1862 8. (c) If alive, give age..... years

8. AGE: Years..... *84* Months..... *2* Days..... *16* If less than one day..... hrs. min.

9. Birthplace..... *Dorchester Co. Md*
(Town, county, and state)

10. Usual occupation..... *Farmer*

11. Industry or business

12. Name..... *Wm. E. Johns*

13. Birthplace..... *Dorchester Co. Md.*

14. Maiden name..... *Henrietta Benson*

15. Birthplace..... *Dorchester Co. Md.*

16. Informant..... *Henrietta Sewell*

Address..... *Easton, Md*

17. Burial..... *Burial* Date thereof..... *Apr. 23, 46*
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... *Williamburg Cemetery*

Location..... *Williamburg, Easton, Md*

18. Funeral director..... *John D. Williams*

Address..... *Easton, Md*

19. *4/20* *46* *N. H. Newin*
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... *April 18* 19 *46*, at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *June 4* 19 *44* to *April 18* 19 *46* and that I last saw him alive on *April 18* 19 *46*

Immediate cause of death..... *Chronic endocarditis* DURATION..... *3 yrs.*

Due to.....

Due to.....

Other conditions..... *Bronchial asthma* *4 yrs.*

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE..... *Harvard T. Pratt, M.D.* M. D. or other

Address..... *Easton, Md* Date signed..... *4/20/46*

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RECEIVED

RECEIVED

MAY 3 1946

BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-2)

CERTIFICATE OF DEATH

04096

Reg. Dist. No. 290

1. PLACE OF DEATH:

County East
City or town Boston
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr.
Hospital, institution, or street address where death occurred:
10 Post Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Salt
City or town Boston
(If outside city or town limits, write RURAL and give nearest town)
Street No. 10 Post St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

George Johnson

3. (b) Social Security Number

717-27-9668

4. Sex M 5. Color or race C 6.(a) Single, married, widowed, or divorced Married

8.(b) Name of husband or wife Annis Cheney Johnson

6.(c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) Dec. 15, 1862

8. AGE: Years 83 Months 4 Days 11 If less than one day
.....hrs.min.

9. Birthplace Boston, Mass.
(Town, county and state)

10. Usual occupation Pres. R. R. Co.

11. Industry or business Unknown

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden name Unknown

15. Birthplace

16. Informant Annis Johnson

Address Boston, Ms.

17. (Burial, cremation, or removal, Which?) Date thereof April 29, 1946
(month) (day) (year)

Cemetery or crematory Richmond

Location East of Boston

18. Funeral director W. B. Clark

Address Boston, Ms.

19. 7/29 19 46 D. H. Neerina
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH April 26, 1946 19..... at 11:30 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15, 1945 19..... to April 26, 1946 19.....

and that I last saw him alive on April 9, 1946 19.....

Immediate cause of death

Acute Uremia

Due to Arteriosclerotic Nephritis

Due to

Generalized Arterio-

sclerosis

(Include pregnancy within 8 months of death)

Major findings of operations None

Date of op None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of None

Where did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) None

Means of injury None Injured at work? None

23. SIGNATURE S. P. Lewis M. D. or other

Address St. Michaels, Md Date signed 4.27.46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 3 1946
BUREAU V. M.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 958

CERTIFICATE OF DEATH

Reg. Dist. No. 041294

1. PLACE OF DEATH:

County TalbotCity or town Wittman

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind County TalbotCity or town Wittman

(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, came war _____

3. (a) FULL NAME

Bertha A. Jones

3. (b) Social Security Number

none4. Sex Female5. Color or race white6. (a) Single, married, widowed, or divorced widow6. (b) Name of husband or wife Albert Jones

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Feb. 18, 18878. AGE: Years 59 Months 2 Days 2 If less than one day _____ hrs. _____ min.9. Birthplace Wittman Talbot Co. Ind

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business _____

12. Name John Jones13. Birthplace Wittman Talbot Co. Ind14. Maiden name Elyabeth Marshall15. Birthplace Wittman Talbot Co. Ind16. Informant Verie JonesAddress Wittman, Ind17. Burial Date thereof April 23/1946

(Burial, cremation, or removal? Which?) (month) (day) (year)

Cemetery or crematory ObertLocation St. Michaels. Ind18. Funeral director Newman & HarrisonAddress St. Michaels. Ind.19. 4/23/ 1946 Anna C. Horgan

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 April 1946 at 0010 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1 April 1946 to 20 Apr. 1946and that I last saw him alive on 19 April 1946Immediate cause of death Kidney and heart failureDue to Cardiac diseaseOther conditions Anasarca andhemiplegia

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Dr. Herbert MorrisonAddress St. Michaels, Ind. Date signed 20 Apr 46M. D. author

RECEIVED
APR 24 1945
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1315

CERTIFICATE OF DEATH

 04098290
 Reg. Dist. No.

1. PLACE OF DEATH:

County Eastern
 City or town Boston
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 Years.
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Eastern
 City or town Boston
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 17 Locust St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

HARRIETT JONES

3. (b) Social Security Number

4. Sex <u>Female</u>	5. Color or race <u>Colored</u>	6. (a) Single, married, widowed, or divorced <u>Widowed</u>
6. (b) Name of husband or wife <u>Henry Jones</u>		
7. Birth date of deceased (mo., day, yr.) <u>Sept. 1881</u>		
8. AGE: Years <u>64</u>	Months <u>7</u>	Days <u>—</u>
if less than one day <u>hrs</u> min.		
9. Birthplace <u>Dorchester County, Md.</u> town, county, and state		
10. Usual occupation <u>Domestic</u>		
11. Industry or business <u>At Home</u>		
FATHER	12. Name <u>Eligah Howard</u>	
	13. Birthplace <u>Md.</u>	
	14. Maiden name <u>Margaret Madden</u>	
MOTHER	15. Birthplace <u>Md.</u>	
	16. Informant <u>Beatrice Jones (Daughter)</u>	
	Address <u>Boston, Md.</u>	
17. Burial (Burial, cremation, or removal, which?) <u>Burial</u> Date thereof <u>April 5, 1946</u> Cemetery or crematory <u>Unionville Cemetery</u> Location <u>Boston, Md. (Rural)</u>		
18. Funeral director <u>L. Ellis Park</u> Address <u>Boston, Md.</u>		
19. <u>4/5</u> 19 <u>46</u> <u>M. H. Neerie</u> (Date rec'd by registrar) Registrar		

MEDICAL CERTIFICATION

20. DATE OF DEATH <u>April 2</u>	19 <u>46</u> at <u>2 A.</u> M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>March 15</u> 19 <u>46</u> to <u>April 2</u> 19 <u>46</u> and that I last saw him alive on <u>April 1, 1946</u>	
Immediate cause of death <u>Acute Uremia</u>	DURATION <u>17 days</u>
Due to <u>Arteriosclerotic Nephritis</u>	
Due to <u>Generalized Arteriosclerosis - Hypertension</u>	
Other conditions <u>Generalized Arteriosclerosis - Hypertension</u> (Include pregnancy within 3 months of death)	
Major findings of operations <u>None</u>	Date of op. <u>None</u>
Autopsy results <u>None</u>	
PHYSICIAN: Please underline the cause to which death should be charged statistically.	
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide <u>✓</u> Date of <u>✓</u> Where did injury occur? (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury Injured at work? <u>P. B. Shreves</u> <u>A. H. Shreves</u>	
23. SIGNATURE <u>A. H. Shreves</u>	M. D. or other <u>4/4/46</u>
Address <u>Boston, Md.</u>	

RECEIVED
APR 9 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:
 County Talbot
 City or town Cordova
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 months
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Talbot
 City or town Cordova
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME
HARRY MELVIN JONES

3. (b) Social Security Number

4. Sex male 5. Color or race black 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) February 19, 1946 6. (c) If alive, give age _____ years

8. AGE: Years _____ Months 2 Days 1 If less than one day _____ hrs. _____ min.

9. Birthplace Cordova Md
 (Town, county, and state)

10. Usual occupation infant

11. Industry or business _____

FATHER 12. Name Walter Jones

13. Birthplace Cordova Md.

MOTHER 14. Maiden name Virginia Stanford

15. Birthplace Bridget Md

16. Informant Walter Jones

Address Cordova Md.

17. Personal Date thereof April 20, 1946
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Cordova

Location Cordova Md.

18. Funeral director Walter Jones

Address Cordova Md.

19. 4/20 19 46 H. H. Neer
 (Date reg'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 19 46 at 4:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 19 46 to April 20 19 46
 and that I last saw him alive on April 12 19 46

Immediate cause of death bronchopneumonia DURATION 8 days

Cue to _____

Cue to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Kurt Lederer M.D. M. D. or other _____

Address Cordova Md. Date signed 4/20

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APR 29 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County FAFOT
 City or town FASTON Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 25 Year
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md County Talbot
 City or town Easton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1st. World War
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

LETON EMOY LEDNUM.

3. (b) Social Security Number

213-01-8440

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White married

6. (b) Name of husband or wife Gladys J. Lednum7. Birth date of deceased (mo., day, yr.) June 18, 1888 6. (c) If alive, give age years8. AGE: Years Months Days If less than one day
58 10 1 hrs. min.9. Birthplace Cordova Talbot Co. Md
(Town, county, and state)10. Usual occupation Merchant

11. Industry or business

12. Name Dennis Lednum13. Birthplace Cordova, Talbot Co. Md14. Maiden name Mary Hampton15. Birthplace Talbot Co. Md16. Informant Mary Gladys LednumAddress Easton Md17. Burial Date thereof April 22, 1946
(Burial, cremation, or removal Which?) (month) (day) (year)Cemetery or crematory Spring HillLocation Talbot Co. Md18. Funeral director Ed. WestfordAddress Easton Md19. 4/20 19 46 N.H. Nevins
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 19 46 at 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 19 44 to April 1 19 46and that I last saw him alive on April 1 19 46Immediate cause of death Cardiac embolus

DURATION

Due to ArteriosclerosisDue to ArteriosclerosisOther conditions Hypertension

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. V. Palmer M. D. or otherAddress Easton, Md Date signed 4/20/46

RECEIVED

APR 29 1946

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

CERTIFICATE OF DEATH

04101

Reg. Dist. No. 292

1. PLACE OF DEATH:

County Talbot
 City or town Rural Trappe
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 45 yrs.
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Talbot
 City or town Rural Trappe
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Linna Pryor Leonard

3. (b) Social Security Number

4. Sex F. 5. Color or race W. 6. (a) Single, married, widowed, or divorced M.

6. (b) Name of husband or wife Clyde Leonard

6. (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Feb. 23, 1891

8. AGE: Years 55 Months 16 Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Trappe, Talbot Co., Md.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business _____

12. Name John S. Pryor

13. Birthplace Md.

14. Maiden name Mollie G.

15. Birthplace Md.

16. Informant Linna Leonard

Address Trappe, Md.

17. Buried Date thereof April 11, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Upper Remond

Location Rural Trappe Twp.

18. Funeral director Will Clark

Address Easton, Md.

19. Apr 10 - 19 46 Joseph Bono
 (Date rec'd by registrar) and Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 19 46 at 3:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 46 to Apr 9 - 46

and that I last saw him alive on Apr 8 - 46 19 46

Immediate cause of death Carcinoma of Stomach & lungs & bowels

Secondary to Carcinoma of breast DURATION 7 years

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE Joseph Bono M. D. or other Dr. Bono

Address Trappe, Md. Date signed 4/10/46

RECEIVED
APR 12 1946
BUREAU V. R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 926

CERTIFICATE OF DEATH

 04102 290
 Reg. Dist. No.

1. PLACE OF DEATH: *Jalbot*
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
108 Hammond St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....*Maryland* County.....*Jalbot*
 City or town.....*Jalbot*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....*108 Hammond St.*
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

FANNIE MILLS

3. (b) Social Security Number

4. Sex.....*Female* 5. Color or race.....*Colored* 6. (a) Single married, widowed, or divorced.....*Married*
 6.(b) Name of husband or wife.....*Emory Mills*
 7. Birth date of deceased (mo., day, yr.).....*Nov. 28, 1894* 6.(c) If alive, give age.....*49* years

8. AGE: Years.....*51* Months.....*4* Days.....*16* If less than one day..... hrs. min.

9. Birthplace.....*Jalbot, Md.*
 (Town, county, and state)

10. Usual occupation.....*Domestic*

11. Industry or business.....*At Home*

12. Name.....*Edward Miller*

13. Birthplace.....*Maryland*

14. Maiden name.....*Laura Bridgett*

15. Birthplace.....*Jalbot, Maryland*

16. Informant.....*Emory Mills*

Address.....*Jalbot, Md.*

17. *Funeral* Date thereof.....*April 17, 1946*
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory.....*Richards*

Location.....*Jalbot, Md.*

18. Funeral director.....*J. Ellis Clark*

Address.....*Jalbot, Md.*

19. *4/15* 19 *46* *N. H. Neer*
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....*April 14* 19 *46* at *12:50 P.* M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Mar 8, 1946* to *April 14, 1946* and that I last saw him alive on *April 13, 1946*

Immediate cause of death.....*Heart Disease*

Due to.....*The Rheumatoid Arthritis*

Due to.....*Hypertension*

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....*None*

Autopsy results.....*None*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....*✓* Date of.....*✓*

Where did injury occur?.....*✓* (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....*✓*

Means of injury.....*✓* Injured at work?.....*✓*

23. SIGNATURE.....*P. B. Jones*

Address.....*Jalbot, Md.*

Date signed.....*4/15-46*

RECEIVED

APR 20 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04103 290

1. PLACE OF DEATH. *Salisbury Co.*
County.....
City or town.....*Easton*
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? *4 da.*
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? *4 da.*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....*Maryland* County.....*Caroline*
City or town.....*Easton, Md*
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION) ✓
2(a) If veteran, name war.....

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex.....*Female* 5. Color or race.....*White* 6. (a) Single, married, widowed, or divorced.....*Married*
6. (b) Name of husband or wife.....*Joseph Prechal*
7. Birth date of deceased (mo., day, yr.).....*June 17, 1891* 6. (c) If alive, give age.....*67* years
8. AGE: Years.....*54* Months.....*9* Days.....*29* If less than one day.....*hrs.*.....*min.*

9. Birthplace.....*Czechoslovakia*
(Town, county, and state).....*N. W.*

10. Usual occupation.....

11. Industry or business.....

FATHER 12. Name.....*Roman Richards*13. Birthplace.....*Czechoslovakia*MOTHER 14. Maiden name.....*Richardson*15. Birthplace.....*Czechoslovakia*16. Informant.....*Mrs. Frank Riverskamp*Address.....*1720 Arlington Ave, Relay Md*17. Burial, cremation, or removal (Which?).....*Burial* Date thereof.....*4/16/46*
(month) (day) (year)Cemetery or crematory.....*Oak Hill*Location.....*Easton, Md*18. Funeral director.....*Maurice E. Newman & Son*Address.....*Easton Md.*19. *4/16* *46* *N. H. Newman*
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....*April 15* 19*46* at.....*100 P* M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....*April 11* 19*46*, to.....*April 15* 19*46*, and that I last saw him.....*April 15* 19*46*, alive on.....Immediate cause of death.....*Cardio-renal disease* DURATION.....*1 year*

Due to.....

Due to.....

Other conditions.....*Diabetes mellitus* *5 yrs*

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....*B. Cox* *2nd*

M. D. or other

Address.....*Easton Md* Date signed.....*4-16-46*

RECEIVED

APR 20 1946

BUREAU V. M.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 95d

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County Talbot CountyCity or town Easton, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 12 days

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 12 days

3. (a) FULL NAME

Anton Sandner

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

-

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

83

Years

Months

Days

If less than one day

_____. hrs. _____. min.

9. Birthplace

Austria
(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof May 1, 1946
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County TalbotCity or town Orford
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-29 1946 at 6:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 1, 1946 to April 29, 1946and that I last saw him alive on April 28, 1946

Immediate cause of death

Chronic Myocarditis

DURATION

years

Due to

Due to

Other conditions

Pneumonia type 22

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

23. SIGNATURE

Charles F. Buell M.D.
M. D. or otherAddress 17611 Blvd East Date signed April 29, 1946

Registrar

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MAY 7 1946

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04105 290

1. PLACE OF DEATH:

County Talbot County
 City or town Easton, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 15 days
 Hospital, institution, or street address where death occurred:
Memorial Hospital
 How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Talbot
 City or town Easton Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

John Henry Smith
 4. Sex M 5. Color or race B 6.(b) Single, married, widowed, or divorced single

3. (b) Social Security Number

6.(b) Name of husband or wife _____

8.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) 1-46

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hrs. _____ min.

8. Birthplace Easton Md.
 (Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

12. Name Daniel Smith

13. Birthplace Va.

14. Maiden name Mary Fennay

15. Birthplace Talbot Co. Md.

16. Informant Earl W. Stafford

Address Easton Md

17. Burial Date thereof 4/18/46
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Easton

Location Easton Md

18. Funeral director Earl W. Stafford

Address Easton Md

19. 4/18 19 46 M. H. Neirus
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-17 19 46 at 6 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 3 19 46 to April 17 19 46
 and that I last saw him alive on April 17 19 46

Immediate cause of death _____

DURATION

Tuberculosis Meningitis

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

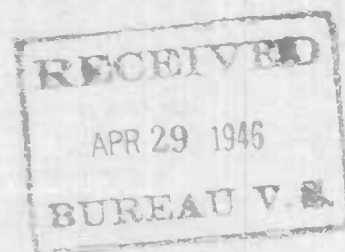
23. SIGNATURE J. J. B. m. p. M. D. or other _____

Address Easton Md Date signed 4/17/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 296

1. PLACE OF DEATH:

County Talbot County
 City or town Easton, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 days
 Hospital, institution, or street address where death occurred:
Memorial Hospital
 How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Caroline
 City or town Tuxm
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Raymond Smith
 4. Sex M. 5. Color or race W. 6.(a) Single, married, or divorced married
 6.(b) Name of husband or wife Mrs Ruth Smith
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Feb. 4, 1899
 8. AGE: Years 47 Months 2 Days 9 If less than one day _____ hrs. _____ min.

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-13 19 46 at 11 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-8-46 19 46 to 4-13 19 46
 and that I last saw him alive on 4-13 19 46
 Immediate cause of death Acute Myocardial failure
 Due to Chronic Emphysema
 Due to _____
 Other conditions Cerebral Hem
 (Include pregnancy within 3 months of death)

DURATION

Major findings of operations _____
 _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE J. Tyler Baker M.D.
 Address Easton Date signed 4-14-46

9. Birthplace Federalburg Md.
 (Town, county, and state)
 10. Usual occupation Laborer
 11. Industry or business Factory
 12. Name George Smith
 13. Birthplace Md.
 14. Maiden name Jola Fisher
 15. Birthplace Deaton, Md.
 16. Informant Mrs. Ruth Smith
 Address Deaton, Md. R.D.
 17. Burial Date thereof 4/19/46
 (Burial, cremation, or removal, which?) (month) (day) (year)
 Cemetery or crematory Canaan
 Location Frederick Md.
 18. Funeral director Harvey Williams
 Address Federalburg, Md.
 19. 4/14 19 46 R.H. Neiries
 (Date rec'd by registrar) Registrar

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APR 20 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1290

1. PLACE OF DEATH:

County Talbot
 City or town Sussex, Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

12 da.

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution?

12 da.

3. (a) FULL NAME

Henry Sullivan

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Black

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Georgia Young

7. Birth date of deceased (mo., day, yr.)

Oct. 10, 1929

6. (c) If alive, give age in years

28

8. AGE:

Years

Months

Days

If less than one day

66529

hrs.

min.

9. Birthplace

Tunis Mills, Md.
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Unknown

12. Name

13. Birthplace

14. Maiden name

Maria Copper

15. Birthplace

Tunis Mills, Md.

16. Informant

Richard Copper

Address

Easton, Md.

17. Burial

(Burial, cremation, or removal? Which?)

Date thereof

4/11/46

Cemetery or crematory

St. Paul's Church

Location

Royal Oak, Md.

19. Funeral director

Edward Sullivan

Address

Easton, Md.

4/10

(Date recd by registrar)

19

46

N.H. Neerue

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County TalbotCity or town Sussex

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 9 1946 at 12:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar. 28 Apr. 9 1946and that I last saw him alive on Apr. 9 1946

Immediate cause of death

Myocardial failure

DURATION

Due to

Chronic Myocarditis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE J. Tyler Balm M.D.

M. D. or other

Address Easton, Md. Date signed 4/10/46

RECEIVED
APR 15 1946
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

CERTIFICATE OF DEATH

C4108

Reg. Dist. No. 290

1. PLACE OF DEATH:

County TalbotCity or town Easton Md
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 da.

Hospital, institution, or street address where death occurred:

Memorial Hospital, Easton, MdHow long at hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County TalbotCity or town Easton
(If outside city or town limits, write RURAL and give nearest town)Street No. 121 N. Harrison St.
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Lillian Margaret Welch

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Wm. Woodrow Welch

7. Birth date of deceased (mo., day, yr.)

Sept. 24, 19156. (c) If alive, give age 31 years

8. AGE:

Years

Months

Days

If less than one day

30727

hrs.

min.

9. Birthplace Sugar Grove, W. Va.

(Town, county, and state)

10. Usual occupation

R. W.

11. Industry or business

FATHER

12. Name

Charles Bowers

13. Birthplace

W. Va.

MOTHER

14. Maiden name

Margaret Harold

15. Birthplace

W. Va.

16. Informant

Wm. W. Welch

Address

Easton Md.

17.

(Burial, cremation, or removal, Which?)

Date thereof

5-2-46
(month) (day) (year)

Cemetery or crematory

Petersburg W. Va.

Location

Petersburg, W. Va.

18. Funeral director

Reis Chas. Co.

Address

Easton, Md.

19.

(Date rec'd by registrar)

19.

46N. B. Merriam
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1946, at 12:07 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4-27-46

19.

to 4-291946and that I last saw him alive on 4-29 1946

Immediate cause of death

apoplexy

Due to

malignant Hypertension

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. B. Cox M.D.

M. D. or other

Address Easton Md Date signed 4-29-46

40121

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RECEIVED

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MAY 7 1946
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (111-2)

CERTIFICATE OF DEATH

04109

Reg. Dist. No. 294

1. PLACE OF DEATH:

County Talbot

City or town Sherwood
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 96

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Talbot

City or town Wittman, md
(If outside city or town limits, write RURAL and give nearest town)

Street No. Wald Wav. 1
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Irving Wells.

3. (b) Social Security Number

218-07-3775

4. Sex man 5. Color or race white 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Eva May Harrison

7. Birth date of deceased (mo., day, yr.) Dec. 16 1889 6.(c) If alive, give age 63 years

8. AGE: Years 56 Months 4 Days 10 If less than one day
.....hrs.min.

9. Birthplace Delaware
(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

12. Name Charles O. Wall

13. Birthplace Delaware

14. Maiden name May Schwatka

15. Birthplace Chesterville, Md.

16. Informant Mrs Irving Wells.

Address Sherwood md

17. Burial Date thereof April 29, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cemetery

Location Sherwood

18. Funeral director Newman + Harrison

Address St. Michaels. md

19. Apr. 29th 19 46 Anna B. Thomas
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 19 46 at 10.15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 to April 26, 1946

and that I last saw him alive on April 26 19 46

Immediate cause of death Myocardial infarction DURATION 1 day

Due to Essential Hypertension 442

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [Signature] M. D. or other

Address [Signature] Date signed 4/29/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 2 1948
TREAS. U.S.

Sub. 1. 1860. 1861. 1862. 1863. 1864. 1865. 1866. 1867. 1868. 1869. 1870. 1871. 1872. 1873. 1874. 1875. 1876. 1877. 1878. 1879. 1880. 1881. 1882. 1883. 1884. 1885. 1886. 1887. 1888. 1889. 1890. 1891. 1892. 1893. 1894. 1895. 1896. 1897. 1898. 1899. 1900. 1901. 1902. 1903. 1904. 1905. 1906. 1907. 1908. 1909. 1910. 1911. 1912. 1913. 1914. 1915. 1916. 1917. 1918. 1919. 1920. 1921. 1922. 1923. 1924. 1925. 1926. 1927. 1928. 1929. 1930. 1931. 1932. 1933. 1934. 1935. 1936. 1937. 1938. 1939. 1940. 1941. 1942. 1943. 1944. 1945. 1946. 1947. 1948. 1949. 1950. 1951. 1952. 1953. 1954. 1955. 1956. 1957. 1958. 1959. 1960. 1961. 1962. 1963. 1964. 1965. 1966. 1967. 1968. 1969. 1970. 1971. 1972. 1973. 1974. 1975. 1976. 1977. 1978. 1979. 1980. 1981. 1982. 1983. 1984. 1985. 1986. 1987. 1988. 1989. 1990. 1991. 1992. 1993. 1994. 1995. 1996. 1997. 1998. 1999. 2000. 2001. 2002. 2003. 2004. 2005. 2006. 2007. 2008. 2009. 2010. 2011. 2012. 2013. 2014. 2015. 2016. 2017. 2018. 2019. 2020. 2021. 2022. 2023. 2024. 2025. 2026. 2027. 2028. 2029. 2030. 2031. 2032. 2033. 2034. 2035. 2036. 2037. 2038. 2039. 2040. 2041. 2042. 2043. 2044. 2045. 2046. 2047. 2048. 2049. 2050. 2051. 2052. 2053. 2054. 2055. 2056. 2057. 2058. 2059. 2060. 2061. 2062. 2063. 2064. 2065. 2066. 2067. 2068. 2069. 2070. 2071. 2072. 2073. 2074. 2075. 2076. 2077. 2078. 2079. 2080. 2081. 2082. 2083. 2084. 2085. 2086. 2087. 2088. 2089. 2090. 2091. 2092. 2093. 2094. 2095. 2096. 2097. 2098. 2099. 2100. 2101. 2102. 2103. 2104. 2105. 2106. 2107. 2108. 2109. 2110. 2111. 2112. 2113. 2114. 2115. 2116. 2117. 2118. 2119. 2120. 2121. 2122. 2123. 2124. 2125. 2126. 2127. 2128. 2129. 2130. 2131. 2132. 2133. 2134. 2135. 2136. 2137. 2138. 2139. 2140. 2141. 2142. 2143. 2144. 2145. 2146. 2147. 2148. 2149. 2150. 2151. 2152. 2153. 2154. 2155. 2156. 2157. 2158. 2159. 2160. 2161. 2162. 2163. 2164. 2165. 2166. 2167. 2168. 2169. 2170. 2171. 2172. 2173. 2174. 2175. 2176. 2177. 2178. 2179. 2180. 2181. 2182. 2183. 2184. 2185. 2186. 2187. 2188. 2189. 2190. 2191. 2192. 2193. 2194. 2195. 2196. 2197. 2198. 2199. 2200. 2201. 2202. 2203. 2204. 2205. 2206. 2207. 2208. 2209. 2210. 2211. 2212. 2213. 2214. 2215. 2216. 2217. 2218. 2219. 2220. 2221. 2222. 2223. 2224. 2225. 2226. 2227. 2228. 2229. 2230. 2231. 2232. 2233. 2234. 2235. 2236. 2237. 2238. 2239. 2240. 2241. 2242. 2243. 2244. 2245. 2246. 2247. 2248. 2249. 2250. 2251. 2252. 2253. 2254. 2255. 2256. 2257. 2258. 2259. 2260. 2261. 2262. 2263. 2264. 2265. 2266. 2267. 2268. 2269. 2270. 2271. 2272. 2273. 2274. 2275. 2276. 2277. 2278. 2279. 2280. 2281. 2282. 2283. 2284. 2285. 2286. 2287. 2288. 2289. 2290. 2291. 2292. 2293. 2294. 2295. 2296. 2297. 2298. 2299. 2300. 2301. 2302. 2303. 2304. 2305. 2306. 2307. 2308. 2309. 2310. 2311. 2312. 2313. 2314. 2315. 2316. 2317. 2318. 2319. 2320. 2321. 2322. 2323. 2324. 2325. 2326. 2327. 2328. 2329. 2330. 2331. 2332. 2333. 2334. 2335. 2336. 2337. 2338. 2339. 2340. 2341. 2342. 2343. 2344. 2345. 2346. 2347. 2348. 2349. 2350. 2351. 2352. 2353. 2354. 2355. 2356. 2357. 2358. 2359. 2360. 2361. 2362. 2363. 2364. 2365. 2366. 2367. 2368. 2369. 2370. 2371. 2372. 2373. 2374. 2375. 2376. 2377. 2378. 2379. 2380. 2381. 2382. 2383. 2384. 2385. 2386. 2387. 2388. 2389. 2390. 2391. 2392. 2393. 2394. 2395. 2396. 2397. 2398. 2399. 2400. 2401. 2402. 2403. 2404. 2405. 2406. 2407. 2408. 2409. 2410. 2411. 2412. 2413. 2414. 2415. 2416. 2417. 2418. 2419. 2420. 2421. 2422. 2423. 2424. 2425. 2426. 2427. 2428. 2429. 2430. 2431. 2432. 2433. 2434. 2435. 2436. 2437. 2438. 2439. 2440. 2441. 2442. 2443. 2444. 2445. 2446. 2447. 2448. 2449. 2450. 2451. 2452. 2453. 2454. 2455. 2456. 2457. 2458. 2459. 2460. 2461. 2462. 2463. 2464. 2465. 2466. 2467. 2468. 2469. 2470. 2471. 2472. 2473. 2474. 2475. 2476. 2477. 2478. 2479. 2480. 2481. 2482. 2483. 2484. 2485. 2486. 2487. 2488. 2489. 2490. 2491. 2492. 2493. 2494. 2495. 2496. 2497. 2498. 2499. 2500. 2501. 2502. 2503. 2504. 2505. 2506. 2507. 2508. 2509. 2510. 2511. 2512. 2513. 2514. 2515. 2516. 2517. 2518. 2519. 2520. 2521. 2522. 2523. 2524. 2525. 2526. 2527. 2528. 2529. 2530. 2531. 2532. 2533. 2534. 2535. 2536. 2537. 2538. 2539. 2540. 25